Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ACCESS MEDIQUIP
PO BOX 421529
HOUSTON TX 77242

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-1909-01

MFDR Date Received
FEBRUARY 3, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "28 TAC §134.402, entitled to fee"

Amount in Dispute: $27,758.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. 1. The requestor provided implants to Spinecare Outpatient Surgery Center for services provided 2/3/11. Spine care did not request separate reimbursement for implants nor did it indicate the requestor was billing separate from Spinecare as required by section (g) of the same rule: 'A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable.' Texas Mutual paid the fee schedule amount for a device intensive procedure consistent with (f)(2)(A) of Rule 134.402 to Spinecare. 2. The requestor submitted its bill…. The bill did not have attached a written agreement from Spinecare substantiating its separate billing for the implants. Further, the requestor did not submit an invoice for the implants or certification- both requirements of the Rule for billing separate payment implants. 3. The requestor submitted a request for reconsideration… This request contained the invoices but no certification. It also contained information concerning a ruling by the 5th Circuit Court of Appeals, which the requestor alleges is applicable to this case. The requestor cites to a U.S. Fifth Circuit opinion and claims its facts are nearly identical to the current dispute. The requestor's assertions are without merit… 4. The requestor then submitted a duplicate request for reconsideration… And still there was no certification. 5. The requestor submitted a final appeal on 1/23/12… In its cover letter it continues to represent that the requestor obtained from Texas Mutual authorization and consent to bill separately, that all materials necessary to process and pay the bill were provided consistent with Texas law and Texas Mutual's own internal processing guidelines, etc. The requestor is not quite correct in its representation of the facts specifically or general. First, Texas Mutual's internal processing guidelines are the 133 series of Rules that given bill submissions by a provider, auditing of bills by a carrier, and requests for reconsiderations. Second, it appears to Texas Mutual that no one associated with the requestor has read the pertinent Rule and specific provisions of that Rule controlling the instant dispute. Rather, it is the case the requestor has not provided all the necessary and required items in order to be paid, i.e. written agreement from Spinecare and certification of invoices. No payment is due. "

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2011	HCPCS Codes L8689, L8687, L8680, L9900, L8681	$27,758.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the fee guidelines for Ambulatory Surgical Centers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 18, 2011, December 22, 2001 and February 8, 2012
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - 765 – Implant provider denied per ASC FG. Separate reimbursement for implantables not requested by the facility per Rule 134.402(g).
   - 766 – Implant provider charges denied per ASC FG. Required signed certification not included per Rule 134.402(G)(1).
   - 138 – Appeal procedures not followed or time limits not met.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 879 – Rule 133.250(B) – Health care provider shall submit the request for reconsideration no later than 11 months from the date of service.
   - 18 – Duplicate claim/service.
   - 678 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(H).

Issues

1. Did the requestor submit the Request for Medical Fee Dispute Resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor bill the services in dispute in accordance with 28 Texas Administrative Code §134.402?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(1) the request for Medical Fee Dispute Resolution was received time and will be reviewed in accordance with Division Rules and guidelines.
2. In accordance with 28 Texas Administrative Code 134.402(g), a facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable. (1)The facility or surgical implant provider requesting reimbursement for the implantable shall: (A)bill for the implantable on the Medicare-specific billing form for ASCs; (B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled. (2)An insurance carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title. (3)Nothing in this rule precludes an ASC or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection. Review of the submitted documentation finds that the requestor did not submit documentation, in the form of a written agreement between the health care provider and requestor that the requestor was to bill the implantables separately. Also, although the requestor submitted invoices, the invoices did not contain the certification required in accordance with this Rule.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for HCPCS Codes L8680, L8681, L8687, L9900 and L8689.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.